VIRGINIA:

In the Supreme Court of Virginia held at the Supreme Court Building in the City of Richmond on Wednesday the 1st day of July, 2020.

Marty D. Foust, Appellant,

against Record No. 190423
Court of Appeals Nos. 1647-17-3 and 0196-18-3

Lawrence Brothers, Inc., et al. Appellees.

Upon a Petition for Rehearing

On consideration of the petition of the appellant to set aside the judgment rendered herein on March 2, 2020 and grant a rehearing thereof, the prayer of the said petition is denied.

Retired Justice McClanahan took no part in the resolution of the petition.

A Copy,

Teste:

Douglas B. Robelen, Clerk

By: 

Deputy Clerk

Corrected Copy

VIRGINIA:

In the Supreme Court of Virginia held at the Supreme Court Building in the City of Richmond on Monday the 2nd day of March, 2020.

Marty D. Foust, Appellant,

against Record No. 190423
Court of Appeals Nos. 1647-17-3 and 0196-18-3

Lawrence Brothers, Inc., et al. Appellees.

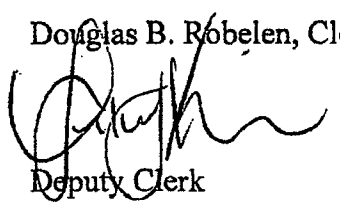
From the Court of Appeals of Virginia

The Court dismisses the petition for appeal filed in the above-styled case for lack of jurisdiction. Code § 17.1-410(A)(2) and (B).

A Copy,

Teste:

Douglas B. Robelen, Clerk

By: 

Deputy Clerk

VIRGINIA:

In the Court of Appeals of Virginia on **Tuesday** *the* **29th** *day of* **January, 2019.**

Marty D. Foust, Appellant,

against Record No. 1647-17-3
Claim No. VA00000463553

Lawrence Brothers, Inc. and
American Interstate Insurance Company, Appellees.

Marty D. Foust, Appellant,

against Record No. 0196-18-3
Claim No. VA00000463553

Lawrence Brothers, Inc. and
American Interstate Insurance Company, Appellees.

From the Virginia Workers' Compensation Commission

Before Judges Beales, Huff and Senior Judge Clements

Marty D. Foust ("claimant") appeals two decisions of the Workers' Compensation Commission. In Record No. 1647-17-3, claimant appeals the Commission's decision on September 15, 2017, dismissing his request for review of the deputy commissioner's March 24, 2016 opinion because the request was untimely. In Record No. 0196-18-3, he appeals the Commission's decision on January 25, 2018, finding that the doctrine of *res judicata* barred his claim seeking benefits for strokes allegedly caused by the pain medication, Atarax, and denying his request for medical treatment of his "thoracic arachnoid web with [spinal] cord compression." Following a motion by Lawrence Brothers, Inc. and American Interstate Insurance Company ("employer"), we consolidated the two appeals on June 26, 2018. We have reviewed the record and the Commission's opinions and find that these appeals are without merit.

BACKGROUND

Record No. 1647-17-3

Claimant, a welder, suffered a compensable injury by accident on April 18, 2011, when he sustained second and third degree burns to his chest, left elbow, abdomen/flank area, and left upper extremity. On June 10, 2015, Lawrence Brothers, Inc. and American Interstate Insurance Company ("employer"), filed an application for hearing asserting that claimant had been released to return to his pre-injury employment and that any continuing disability was not causally related to his April 18, 2011 accident. On July 1, 2015, and on October 12, 2015, claimant filed claims requesting approval of Dr. Karvelas as his treating physician, approval of EMG and nerve conduction studies ordered by Dr. Karvelas, and benefits for the stroke claimant suffered on May 28, 2012. Claimant argued that his burns had damaged his lymphatic system, resulting in his stroke.

On March 24, 2016, the deputy commissioner denied both employer's application and claimant's claims. On April 18, 2017, claimant filed a letter requesting that the Commission review the deputy commissioner's decision. On September 15, 2017, the Commission dismissed the request, ruling that it had lost jurisdiction to review the deputy commissioner's decision because claimant's request for review was untimely. On October 12, 2017, claimant noted an appeal to this Court from the Commission's decision.

Record No. 0196-18-3

Claimant filed requests for hearings on December 5, 2016, February 21, 2017, and April 26, 2017, asserting that he had suffered strokes and "mini-strokes" resulting from Atarax, a drug prescribed by Dr. Ajam, his pain management physician. In addition to seeking medical treatment and compensation for his strokes, claimant also sought medical treatment and compensation for chronic pain and for spinal scar neuroma, which he asserted led to "thoracic arachnoid web with [spinal] cord compression." Finally, claimant sought compensation for his disfigurement from scarring, a change in his treating neurologist, and compensation for raises and vacation pay that he would have received from his employer, "but for" his injury.

On June 26, 2017, the deputy commissioner denied claimant's request seeking benefits for his stroke, ruling that they were barred by the doctrine of *res judicata*. The deputy commissioner concluded that claimant had previously litigated his claim seeking compensation for his stroke when he asserted that his stroke resulted from damage to his lymphatic system. In the alternative, the deputy commissioner found that the medical evidence was insufficient to prove that Atarax caused claimant's stroke.

The deputy commissioner granted claimant's request for a panel of neurologists and also ordered that employer provide a panel of pain management physicians. However, the deputy denied claimant's request for compensation for chronic pain and for raises and vacation pay. The deputy retained jurisdiction over the claim for permanent partial disability due to scarring and disfigurement, finding that the claim was not yet ripe. Finally, the deputy awarded benefits to claimant for medical treatment of the suspected scar neuroma in the area of claimant's skin graft, but concluded that evidence failed to prove that the thoracic arachnoid web condition was causally connected to the workplace injury.

On June 26, 2017, claimant filed a request for review of the deputy commissioner's decision, asserting that the deputy commissioner had erred in denying his request to make employer "responsible for the treatment of his strokes and mini-strokes," and in denying his "request for medical treatment of the thoracic arachnoid web with [spinal] cord compression." On January 25, 2018, the Commission affirmed the deputy commissioner's decision that claimant had previously litigated the cause of his stroke, and therefore, his claim that the Atarax caused his stroke was barred by *res judicata*. The Commission also affirmed the deputy commissioner's decision finding the evidence insufficient to prove that the thoracic web with cord compression was causally related to claimant's workplace accident. These appeals followed.

ANALYSIS

Claimant, as the appellant in these matters, has the burden of showing that reversible error occurred below. Lutes v. Alexander, 14 Va. App. 1075, 1077 (1992). It is well settled that an appellate court does not "search the record for errors" or "seek out the substance of all contentions made during the progress of a trial"

or a Workers' Compensation Commission proceeding. Law v. Commonwealth, 171 Va. 449, 455 (1938); see also Buchanan v. Buchanan, 14 Va. App. 53, 56 (1992).

Record No. 1647-17-3

On February 2, 2018, claimant filed his opening brief and appendix. On February 8, 2018, the Court notified claimant that his brief did not comply with several requirements in Rule 5A:20. Specifically, we informed claimant that his brief failed to satisfy the requirements in Rule 5A:20(c), (d), (e), and (h). The Court notified claimant that the certificate did not indicate the number of words in the brief and whether the number of words exceeded the applicable word limit. We also informed him that his brief did not comply with Rule 5A:20(c) because it did not contain assignments of error, or references to the pages of the transcript, statement of facts, record, or appendix where each assignment of error was preserved. The Court stated further that the statement of facts in the brief failed to comply with Rule 5A:20(d) because it did not cite the pages of the transcript, statement of facts, record, or appendix where the facts were established. In addition, claimant was notified that Rule 5A:20(e) required that his brief include the standard of review for each assignment of error. Finally, the Court informed claimant that the certificate did not specify whether he desired oral argument or whether a copy of his brief had been provided to opposing counsel, as required by Rule 5A:20(h).

The Court directed claimant to correct the deficiencies and to file an amended opening brief by February 18, 2018, and warned that failure to file an amended brief in compliance with the Rules of Court could result in summary affirmance of the Commission's decision. After receiving an extension of the filing deadline, claimant filed an amended opening brief on February 23, 2018; however, the brief did not comply fully with the Rules of Court.

On March 2, 2018, employer filed a motion to dismiss the appeal and to summarily affirm the Commission's decision because claimant's brief did not comply with the Rules of Court. In the alternative, employer sought an extension of time within which to file its responsive brief. On March 16, 2018, the Court entered an order granting claimant another extension of time within which to file an amended opening brief

and granting employer an extension of time to file its response. After receiving additional extensions of time, claimant filed a second amended opening brief and appendix on April 9, 2018, and another "amended pleading brief" on May 7, 2018.

The amended opening briefs filed on April 9, 2018 and on May 7, 2018, do not comply with the Rules of Court. They do not comply with Rule 5A:20(c), which requires that the opening brief include assignments of error and to specify where in the record the arguments contained in the assignments of error were preserved. Although the amended opening brief filed on April 9, 2018 includes a section entitled "Question," followed by enumerated allegations, none of the enumerated allegations assigns error to the Commission's decision on September 15, 2017.[1]

The amended opening brief filed on May 7, 2018 lists twelve "issues." Of those issues, only the fifth issue assigns error to rulings by the Commission. The fifth issue asserts that "[a]ll of the full Commission Marshall, Rapaport be dismissed or reversed because the opinion[] was thru [sic] fraudulent acts. And Newman[.] [sic]" The remaining "issues" assign error to rulings by the deputy commissioner[2] and allege

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[1] "Question 9" in the amended opening brief filed on April 9, 2018, arguably addresses a ruling by the Commission when it asks:

> Did the Commissi[o]ner Burkholder, Marshall, Newman, and Rapaport commit fraud by stating in Record # 0526-17-3 . . . [that] they agreed with Commissioner Burkholder on the opinion by [C]ommissioner Marshall, March 8, 2017, which they all agreed with Commissioner Burkholder when they all said that they didn't know what Doctor I needed or wanted?

The same amended brief also appended three "questions," one of which asked: "Did the Commissioner, Marshall, Rapaport and Newman commit bias and fraud by agreeing with Commissioner Burkholder on the subject. They didn't know what kind of doctor I wanted or needed [i]n [R]ecord No. 0526-17-3." While both "Question 9" and the appended question address rulings by the Commission, they assign error to rulings in a separate appeal, Record Number 0526-17-3, rather than the rulings that are the subject of the appeal in Record Number 1647-17-3.

[2] We are a court of limited jurisdiction. Canova Elec. Contracting, Inc. v. LMI Ins. Co., 22 Va. App. 595, 599 (1996). Unless a statute confers jurisdiction in this Court, we are without power to review an appeal. Id. Pursuant to Code § 17.1-405(2) and (4), the Court of Appeals has appellate jurisdiction over any final decision of the Virginia Workers' Compensation Commission and any interlocutory decree or order in such a matter involving the granting, dissolving, or denying of an injunction or "adjudicating the principles of

fraudulent and criminal conduct by the Commission, attorneys, medical care providers, and employer. The "issues" also ask that this Court "dismiss" or disregard certain medical records and medical opinions.

Although appellant asserts generally that "the opinion" was rendered through fraud, he does not assign error to a specific ruling by the Commission; thus, there is nothing for us to review. See Amos v. Commonwealth, 61 Va. App. 730, 745 (2013), aff'd, 287 Va. 301 (2014). Even assuming that the broad language in claimant's opening brief articulates assignments of error, it does not state where in the record the issues in the assignments of error were preserved for appeal, as required by Rule 5A:20(c). In addition, although the opening brief[3] contains a section entitled "Facts," the statement of facts does not comply with Rule 5A:20(d)[4] because it does not refer to the pages in the transcript, appendix, written statement of facts, or record where the facts were established.

Furthermore, the opening brief does not comply with Rule 5A:20(e), which requires that the opening brief include "[t]he standard of review and the argument (including principles of law and authorities) relating to each assignment of error." Assuming that the opening brief contains assignments of error, it does not include the standard of review governing each assignment of error. Further, the brief does not contain legal argument addressing the Commission's ruling that it lacked jurisdiction to consider claimant's untimely appeal or legal authorities addressing the Commission's decision.[5]

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a cause." Code § 17.1-405(4). Thus, we are not vested with statutory authority to review directly the deputy commissioner's decisions.

[3] The term "opening brief" includes the amended opening briefs filed on April 9, 2018, and on May 7, 2018.

[4] Rule 5A:20(d) requires an opening brief to contain "[a] clear and concise statement of the facts that relate to the assignments of error, with reference to the pages of the transcript, written statement, record, or appendix."

[5] Legal authorities are scattered throughout the opening brief, but they do not support an assignment of error relating to the Commission's decision.

Record Number 0196-18-3

On May 14, 2018, appellant filed his opening brief and appendix. On June 14, 2018, the Court notified appellant that his opening brief failed to comply with Rule 5A:20 in several respects. The brief did not contain: (1) a table of contents, in violation of Rule 5A:20(a); (2) assignments of error, or references to the record, transcript, statement of facts, or appendix where each assignment of error was preserved, in violation of Rule 5A:20(c); (3) a section entitled "statement of facts," with supporting references to the record, transcript, statement of facts, or appendix, in violation of Rule 5A:20(d); (4) the standard of review governing each assignment of error, in violation of Rule 5A:20(e); (5) a certificate stating whether oral argument was waived, in violation of Rule 5A:20(h); (6) a certificate indicating that a copy of the pleading had been provided to opposing counsel, in violation of Rule 5A:20(h); and (7) a table of contents and page numbers in the appendix, in violation of Rule 5A:25(e).

After granting claimant several extensions to file an amended opening brief, appellant finally filed his amended opening brief and amended appendix on November 8, 2018. The amended opening brief includes a table of contents and a table of authorities, but no page references. It does not include "[a] statement of the assignments of error with a clear and exact reference to the page(s) of the transcript, written statement, record, or appendix where each assignment of error was preserved in the trial court."[6] Rule 5A:20(c). Because appellant does not assign error to a ruling by the Commission in this case, there is nothing for us to review. See Amos, 61 Va. App. at 745. Even assuming that the opening brief assigned error to the Commission's rulings, it does not state where in the record the issues in the assignments of error were preserved for appeal, as required by Rule 5A:20(c), or the governing standard of review for each assignment of error, as required by Rule 5A:20(e). Although the brief contains legal authorities, they do not address the Commission's decision that *res judicata* barred claimant from seeking benefits based on his claim that Atarax caused his

[6] The amended opening brief contains a section entitled "Procedural History" and a section entitled "Facts, Fraud and Error[s]," but neither section cites a ruling by the Commission that was in error. Further, neither section cites where in the record the alleged error occurred.

strokes and its finding that the evidence was insufficient to prove that the thoracic web with cord compression was causally related to claimant's workplace accident.

The purpose of assignments of error is to "point out the errors with reasonable certainty in order to direct [the] court and opposing counsel to the points on which appellant intends to ask a reversal of the judgment, and to limit discussion to these points." Carroll v. Commonwealth, 280 Va. 641, 649 (2010) (quoting Yeatts v. Murray, 249 Va. 285, 290 (1995)). An appellant must "lay his finger on the error." Id. Claimant failed to do so.

In addition, although the amended opening brief contains a section entitled "Procedural History" and a section entitled "Facts, Fraud and Error[s]," it does not include a "statement of facts" that complies with Rule 5A:20(d).[7] It does not contain a separate statement of facts that relates to each assignment of error or refer to the pages in the transcript, appendix, written statement of facts, or record where these facts were established.

CONCLUSION

"Unsupported assertions of error do not merit appellate consideration." Fadness v. Fadness, 52 Va. App. 833, 850 (2008) (quoting Jones v. Commonwealth, 51 Va. App. 730, 734 (2008)). "If an appellant believes that the [C]ommission erred, it is incumbent upon him 'to present that error to us with legal authority to support [his] contention.'" Ceres Marine Terminals v. Armstrong, 59 Va. App. 694, 708 (2012) (quoting Fadness, 52 Va. App. at 851). "[I]t is not the function of this Court to 'search the record for error in order to interpret the appellant's contention and correct deficiencies in a brief.'" West v. West, 59 Va. App. 225, 235 (2011) (quoting Buchanan, 14 Va. App. at 56). "Nor is it this Court's 'function to comb through the record . . . in order to ferret-out for ourselves the validity of [appellant's] claims.'" Burke v. Catawba Hosp., 59 Va. App. 828, 838 (2012) (quoting Fitzgerald v. Bass, 6 Va. App. 38, 56 n.7 (1988) (*en banc*)).

[7] Rule 5A:20(d) requires an opening brief to contain "[a] clear and concise statement of the facts that relate to the assignments of error, with reference to the pages of the transcript, written statement, record, or appendix."

"[W]hen a party's failure to strictly adhere to the requirements of Rule 5A:20(e) is significant, the Court of Appeals may . . . treat a[n assignment of error] as waived." Atkins v. Commonwealth, 57 Va. App. 2, 20 (2010) (quoting Parks v. Parks, 52 Va. App. 663, 664 (2008)). A *pro se* litigant "is no less bound by the rules of procedure and substantive law than a defendant represented by counsel." Townes v. Commonwealth, 234 Va. 307, 319 (1987); see also Francis v. Francis, 30 Va. App. 584, 591 (1999) ("Even *pro se* litigants must comply with the rules of court."). Here, we find that claimant's failure to comply with Rule 5A:20 is significant. See Jay v. Commonwealth, 275 Va. 510, 520 (2008). Claimant was provided with an opportunity to cure the defects in his opening briefs and failed to do so.

Accordingly, we affirm for the reasons stated by the Commission in its final opinions.[8] See Foust v. Lawrence Brothers, Inc., et al., JCN VA00000463553 (Va. Wrk. Comp. Sept. 15, 2017), and Foust v. Lawrence Brothers, Inc., et al., JCN VA00000463553 (Va. Wrk. Comp. Jan. 25, 2018). We dispense with oral argument and summarily affirm because the facts and legal contentions are adequately presented in the materials before the Court and argument would not aid the decisional process. See Code § 17.1-403; Rule 5A:27.

This order shall be certified to the Virginia Workers' Compensation Commission.

A Copy,

Teste:

Cynthia L. McCoy, Clerk

By: Marty K P. Ring

Deputy Clerk

[8] Because we summarily affirm the Commission's decision, we need not address employer's motion to dismiss both appeals based on the deficiencies in claimant's opening briefs.

VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

Opinion by MARSHALL
Commissioner

Jan. 25, 2018

MARTY FOUST v. LAWRENCE BROTHERS, INC
AMERICAN INTERSTATE INS CO, Insurance Carrier
AMERICAN INTERSTATE INS CO, Claim Administrator
Jurisdiction Claim No. VA00000463553
Claim Administrator File No. 201189641VA
Date of Injury April 18, 2011

no date on the entry that was taking out of the opinion of Oct 28, 2014

Commissioner Lee opinion Oct 14, 2014 When she said that they did not know what kind of doctor I ask for. But I did ask the commissioner Barkholde for a panel of neurologist from 2013 until 2 It in the transcipt of 2013, 2014, 2015, 2017

Marty Foust,[1]
Claimant pro se.

Ramesh Murthy, Esquire
For the Defendants.

REVIEW on the record by Commissioner Marshall, Commissioner Newman and Commissioner Rapaport at Richmond, Virginia.

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A June 26, 2017, Opinion found doctrine of res judicata barred the claim for a prescription for Atarax. It also denied a request for medical treatment of thoracic arachnoid web with cord compression. The claimant requests review.

The Opinion also determined the defendants were responsible for a new panel of neurologists and res judicata did not bar that request. The Opinion held the defendants were responsible for medical treatment of "suspected scar neuroma." The defendants request review. We AFFIRM.[2]

---

[1] On December 19, 2017, the Commission granted the claimant's request to remove Mark T. Hurt, Esquire, as his counsel. Hurt represented the claimant on review, and we have entered an award for attorney's fees.

[2]Considering the issues involved and the complete record developed at the hearing and before the Commission, we find oral argument is unnecessary and would not be beneficial in this case. Va. Workers' Comp. R. 3.4; see Barnes v. Wise Fashions, 16 Va. App. 108, 112, 428 S.E.2d 301, 303 (1993).

I. Material Proceedings

The claimant sustained second and third degree burns to his chest, left elbow, abdomen/flank area and left upper extremity in an April 18, 2011 work accident. He is under an open Award for temporary total disability.

Dr. Kamal Ajam discharged the claimant from his care on October 28, 2013. On November 8, 2013, the claimant requested a panel of pain management physicians. In an October 28, 2014 Opinion Deputy Commissioner Burkholder ordered the defendants to provide a panel of pain management physicians. On April 3, 2015, the full Commission reversed. We concluded the claimant had withdrawn his request. We recognized Dr. Badlani was the treating neurologist. We noted if he would not treat the claimant or if his care was inappropriate, the claimant could file a claim for a change in treating neurologists.

On May 19, 2016, the claimant requested a "panel of treating physicians." On October 14, 2016, Deputy Commissioner Lee denied the request because the claimant had not specified what type of physician he wanted. A March 8, 2017, Opinion affirmed. The Commission treated a December 5, 2016, correspondence as a request for a neurologist, referring the request to our Claims Services Department.

On October 12, 2015, the claimant asserted his 2012 stroke was a compensable consequence of the 2011 work accident.

The claimant filed additional applications on February 21, 2017 and April 26, 2017. The claimant asserted Dr. Kamal Ajam's prescription of the medication Atarax caused a "brain injury." At the hearing, the claimant asserted he suffered strokes in 2012 and 2013 and mini-strokes. He asserted the Atarax medication caused the strokes. He requested a change in his treating

neurologist, treatment for chronic pain, vacation pay and raises, compensation for scarring or body disfigurement and medical treatment and compensation for scar neuroma or tumors from his burn injury. He indicated these were diagnosed as "thoracic arachnoid web with cord compression."

A March 24, 2016, Opinion concluded the claimant's 2012 stroke was not a compensable consequence of his original injury. On September 15, 2017, the Commission dismissed the claimant's untimely request for review.

The Deputy Commissioner denied the claim that Atarax caused strokes. The Deputy Commissioner concluded:

> We find that the claimant's claim that his stroke was caused by Dr. Ajam's prescription of the medication Atarax is barred by the doctrine of res judicata. The claimant previously litigated a claim to establish the compensability of his stroke. The Deputy Commissioner's March 24, 2016 Opinion ruled in favor of the defense on that claim. The claimant did not request review of that decision within the 30 day period required by Va. Code § 65.2-705. His April 18, 2017 request for review falls long after the statutory deadline, and the full Commission is now without jurisdiction to review that decision. McCarthy Elec. Co. v. Foster, 17 Va. App. 344, 345, 437 S.E.2d 246, 247 (1993).
>
> In the prior proceeding, claimant advanced the theory that damage to his lymphatic system from the burn injury was responsible for the stroke. In the present litigation, claimant advances a different theory of recovery, i.e., that the stroke was caused by Atarax prescribed for the claimant by Dr. Ajam. The doctrine of res judicata "proceeds upon the principle that one person shall not the second time litigate . . . precisely the same question, particular controversy, or issue, which has been necessarily tried and finally determined, upon the merits, by a court of competent jurisdiction." Wood v. Allison Apparel Marketing, 11 Va. App. 352, 355, 398 S.E.2d 110, 112 (1990). It is well established that the doctrine of res judicata is applicable to the Commission, and "bars relitigation of the same cause of action, or any part thereof which could have been litigated between the same parties and their privies." K & L Trucking Co., Inc. v. Thurber, 1 Va. App. 213, 219, 337 S.E.2d 299, 302 (1985)(citation omitted). Having litigated his claim for the compensability of his stroke to a judgment by the Commission once already, the claimant is now barred from trying that claim again under a different theory of recovery. See also, James v. Gabriel Brothers, Inc., JCN VA00000972120 (Dec. 6, 2016) (consideration of an application filed for purpose of presenting

> additional evidence in support of a claim that has been previously denied barred by res judicata). Res judicata bars the claimant's effort to get a second bite at the apple by advancing a new theory of why the stroke should be the responsibility of the employer and carrier.
>
> [. . . .] For all of the foregoing reasons, the claimant's claim for the compensability of his stroke will be denied.

(Op. 15-18.) (footnotes omitted)

Regarding the request for medical treatment, the Deputy Commissioner concluded:

> The claimant seeks a panel of neurologists, which the defendants state they are prepared to offer him in the event their preclusion defense to this claim is not successful. The defendants argue that because the claimant could have brought the claim for reasonable, necessary and causally related medical treatment by a neurologist at an earlier point in time, that claim is now barred by res judicata. We do not agree.
>
> Unlike the claim for the stroke, the claimant's claim for treatment by a neurologist has not previously been tried to a final determination by the Commission. Furthermore, the defendants' argument that a claim for medical treatment must be asserted or it will be waived and subsequently precluded fails to make what we perceive to be the critical distinction between a claim for injuries to be declared compensable and covered by an award of the Commission on the one hand and a claim for medical treatment under an outstanding award already in place from the Commission on the other.
>
> [. . . .]

We hold that the claimant's award of medical benefits remains legally enforceable against the defendants for the claimant's lifetime.

> The medical record sufficiently establishes, and the defendants concede, that the claimant suffers from neuropathic pain as a result of his injuries which should be evaluated by a neurologist. Therefore, we will order the defendants to provide the claimant with a panel of neurologists within 30 days from date of this Opinion.

(Op. 18-20.) (footnotes omitted)

Regarding the medical treatment for suspected scar neuroma, the Deputy Commissioner concluded:

> We next address the claimant's request for medical treatment of the suspected scar neuroma. The medical reports by Dr. Molnar, Dr. Hultman and Dr. Karvelas convince us that it is more probable than not that the scar neuroma assessed by those physicians is causally related to the claimant's compensable injury. At a minimum, the exploratory procedure is required to determine whether a scar neuroma is present in the area of the claimant's skin graft. Medical procedures to determine the extent of an occupational injury and its causal relationship to symptoms that may or may not be related to the compensable injury are the responsibility of the defendants. Noblin v. Brunswick Cnty. Pub. Schs., JCN VA00000426554 (Mar. 13, 2003)(citing Garcia-Arana v. Mary Washington College, 70 O.I.C. 282 (1991)). Therefore, we find that the evidence before us in the present record is sufficient to sustain the claimant's burden of proof. The proposed medical treatment at issue, exploratory surgery and excision of the symptomatic neuroma, shall be the responsibility of the employer and carrier.

(Op. 22-23.)

Regarding the request for treatment of thoracic arachnoid web condition, the Deputy Commissioner concluded:

> We now consider the claim for medical treatment of the thoracic arachnoid web condition. We find that the evidence fails to sustain the claimant's burden of proof that the arachnoid web is causally related to the compensable injury. The report from the neurosurgeons at the University of Virginia states that it is plausible that the claimant's accident could have contributed to the pathology seen on the MRI scan of his thoracic spine. In our view, the opinion of the UVA physicians at most states that it is possible that the arachnoid web is related to the work injury. Such evidence, however, is not sufficient to support a finding of fact that it is more probable than not that the two are related. Additionally, as the claimant candidly testified, his doctors have not connected the arachnoid web condition to the 2011 work injury. It is his own conclusion that the two are related. In this regard, we find that the evidence fails to sustain the claimant's burden of proof, and treatment of the thoracic arachnoid web shall not be the responsibility of the employer and carrier.

(Op. 23.)

II. Findings of Fact and Rulings of Law

A. Atarax

We agree with the Deputy Commissioner's factual findings and legal conclusions. "The doctrine of *res judicata* is applicable to decisions of deputy commissioners and the full commission." Rusty's Welding Serv. v. Gibson, 29 Va. App. 119, 128, 510 S.E.2d 255, 259 (1999) (citation omitted). "As the party seeking to assert *res judicata*, employer must prove that the deputy commissioner rendered a final judgment in its favor." Id. (citation omitted).

This doctrine "'precludes the re-litigation of a claim or issue once a final determination on the merits has been reached.'" Gibson, 29 Va. App. at 128, 510 S.E.2d at 259 (quoting Gottlieb v. Gottlieb, 19 Va. App. 77, 81, 448 S.E.2d 666, 669 (1994)).

"Claims precluded by *res judicata* include those 'made or tendered by the pleadings,' as well as those 'incident to or essentially connected with the subject matter of the litigation, whether the same, as a matter of fact, were or were not considered.'" Brock v. Voith Siemens Hydro Power Generation, 59 Va. App. 39, 46, 716 S.E.2d 485, 488 (2011) (citation omitted). "Where an application for a change in condition is filed for the sole purpose of presenting additional evidence in support of a claim that has previously been denied, *res judicata* will bar reconsideration of the claim." Fodi's Inc. v. Rutherford, 26 Va. App. 446, 448, 495 S.E.2d 503, 504 (1998) (citations omitted).

The claimant contends that at the time of the March 24, 2016 decision there was no medical evidence to put him on notice that Atarax caused a stroke.

The claimant previously alleged damage to his lymphatic system from the burn injury led to his stroke. The hearing on that claim was on November 9, 2015. His primary care physician,

Dr. Matthew Johnson, stated the claimant's damaged lymphatic system was unable to clear plaque from his arteries, causing the stroke. The defendants presented evidence to contradict his opinion. The Deputy Commissioner determined the stroke was a "noncompensable consequence of a compensable consequence" and alternatively that Dr. Johnson's opinion was not entitled to preponderating evidentiary weight.

The claimant now alleges Atarax caused his 2012 and 2013 strokes and mini-strokes. The doctrine of res judicata prohibits the re-litigation of this claim under a new theory of the cause of the claimant's stroke or subsequent strokes. The previous decision was in the defendants' favor, and it is final. We will not litigate that decision again because the claimant did not identify the correct opinions to support his claim.

B. Neurologist

We agree with the Deputy Commissioner's factual findings and legal conclusions. The defendants contend the doctrine of res judicata or collateral estoppel bar the claim for a panel of neurologists. They assert that the claimant's previous request for a pain management physician was litigated; therefore, the claimant had a full and fair opportunity to seek a neurologist. We disagree.

The Commission did not previously rule on the claimant's request a panel of neurologists. Hence, the doctrine of res judicata does not bar this request. The claimant suffers from neuropathic pain and the defendants are responsible for treatment with a neurologist.

C. Thoracic Arachnoid Web with Cord Compression

We agree with the Deputy Commissioner's factual findings and legal conclusions. The medical evidence was not sufficient to meet the claimant's burden of proof. Dr. Mark Shaffrey, a neurosurgeon at UVA, indicated this condition "could certainly be contributing to Mr. Foust's symptomatology." He later opined, "it is plausible that the trauma of dropping and rolling when on fire could have contributed to this pathology." The claimant argues the Deputy Commissioner denied the request because the treating physicians did not use the correct legal phraseology. We disagree. The physician's assessment does not mean it was more probable than not. To the extent we rely on medical evidence, the preponderance of the evidence standard requires more than an opinion of "could be" or "it is plausible." Thus, the claimant did not convince us the thoracic arachnoid web with cord compression was related to the work accident.

D. Suspected Scar Neuroma

We agree with the Deputy Commissioner's factual findings and legal conclusions. The defendants concede that diagnostic studies are the defendants' responsibility to determine causation. However, they assert that surgery is not a diagnostic study. They do not present any legal precedent or statutory law for this proposition.

The Court of Appeals of Virginia held in Clements & Sons v. Harris, 52 Va. App. 447, 457, 663 S.E. 2d 564, 569 (2008):

> The commission has consistently interpreted "necessary medical attention" to include reasonable and necessary diagnostic procedures, even though ultimate causation of the condition has not been firmly established and even if the procedures reveal that the condition is not in fact related to the compensable injury. "Code § 65.2-603 should be construed liberally in favor of the claimant, in harmony with the Act's humane purpose." Papco Oil Co. v. Farr, 26 Va. App. 66, 74, 492 S.E.2d 858, 861-62 (1997).

In Harris, the defendants were responsible for right shoulder arthroscopy. Id. at 457-458, 663 S.E.2d at 570. "Diagnostic" is not limited to "studies." It also includes surgical procedures. The procedure at issue will determine if the scar neuroma is present in the area of the claimant's skin graft, and the physician will excise the neuroma. Thus, the defendants are responsible for this procedure.

III. Conclusion

We AFFIRM the Deputy Commissioner's June 26, 2017 Opinion.

We AWARD an attorney's fee of $1,000 to Mark Hurt, Esquire, for legal services rendered the claimant, the payment of which is the claimant's responsibility.

This matter is hereby removed from the Review docket.

APPEAL

You may appeal this decision to the Court of Appeals of Virginia by filing a Notice of Appeal with the Commission and a copy of the Notice of Appeal with the Court of Appeals of Virginia within 30 days of the date of this Opinion. You may obtain additional information concerning appeal requirements from the Clerks' Offices of the Commission and the Court of Appeals of Virginia.

VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

Opinion by RAPAPORT
Commissioner

Sept. 15, 2017

MARTY FOUST v. LAWRENCE BROTHERS, INC
AMERICAN INTERSTATE INS CO, Insurance Carrier
AMERICAN INTERSTATE INS CO, Claim Administrator
Jurisdiction Claim No. VA00000463553
Claim Administrator File No. 201189641VA
Date of Injury April 18, 2011

The Opinion was Record Number 1647-17-3 filed as a appeal with the Virginia Court of Appeals. I did not with-draw.

Mark T. Hurt, Esquire
For the Claimant.[1]

Ramesh Murthy, Esquire
For the Defendants.

REVIEW on the record by Commissioner Marshall, Commissioner Newman and Commissioner Rapaport at Richmond, Virginia.

The claimant requests review of the Deputy Commissioner's March 24, 2016 Opinion. We DISMISS the claimant's untimely Request for Review.

I. Material Proceedings[2]

The claimant suffered a compensable injury by accident on April 18, 2011. Pursuant to a January 5, 2012 Opinion, based upon the parties' stipulations, the Commission found that the claimant sustained second and third degree burns to the chest, left elbow, abdomen/flank area and

[1] The claimant has been represented by multiple counsel since December 2011, including J. Aaron Thomas, Esquire, who represented him at the November 9, 2015 hearing, the subject of this review. Mr. Thomas and the claimant's other attorneys withdrew as counsel prior to or following the November 9, 2015 hearing. The claimant filed the current Request for Review pro se. Mark. T. Hurt, Esquire, noted his representation of the claimant on June 1, 2017, prior to his submission of the claimant's Written Statement in this matter.

[2] We only briefly summarize the procedural history to the extent necessary for this Opinion.

left upper extremity and was entitled to temporary total disability benefits beginning April 19, 2011.

On June 10, 2015, the defendants filed an Employer's Application for Hearing asserting the claimant was released to return to his pre-injury employment and any continuing disability was not causally related to the claimant's April 18, 2011 compensable accident.

On July 1, 2015, the claimant filed a Claim for Benefits requesting Dr. Karvelas be recognized as an authorized treating physician and approval for EMG and nerve conduction studies ordered by Dr. Karvelas. On October 12, 2015, the claimant amended his claim to also allege he suffered a May 28, 2012 stroke as a compensable consequence of his compensable injury by accident.

The claimant defended the defendants' application on the grounds he was incapable of performing all of his pre-injury job duties and the job description provided to the IME physician was inaccurate. The defendants defended the claimant's claim on the grounds Dr. Karvelas was not an authorized treating physician, the medical treatment at issue was not reasonable, necessary or causally related to the claimant's compensable injury, and the claimant's 2012 stroke was not a compensable consequence.

Deputy Commissioner Burkholder conducted an evidentiary hearing on November 9, 2015. On March 24, 2016, he denied the defendants' application and the claimant's claim.

On April 18, 2017, the claimant filed a letter requesting review of the Deputy Commissioner's decision. Claimants' counsel filed a Written Statement requesting the Commission reverse the Deputy Commissioner's finding that the claimant's 2012 stroke was not

a compensable injury. In response, the defendants filed a Motion to Dismiss pursuant to Va. Code § 65.2-705.

II. Findings of Fact and Rulings of Law

Rule 3.1 of the Rules of the Virginia Workers' Compensation Commission provides, in part, that "[a] request for review of a decision, order or award of the Commission shall be filed by a party in writing with the Clerk of the Commission within thirty (30) days of the date of such decision, order or award." Pursuant to Va. Code § 65.2-705, "[i]f an application for review is made to the Commission within 30 days after issuance of an award, the full Commission, . . . shall review the evidence or, if deemed advisable, as soon as practicable, hear the parties at issue, their representatives, and witnesses. . . . " The 30-day period established is jurisdictional, and the Commission has no jurisdiction to review a case if the request for review is not filed within that time period, except to correct for fraud or mutual mistake. See K & L Trucking Co. v. Thurber, 1 Va. App. 213, 218, 337 S.E.2d 299, 302 (1985) (citing Harris v. Diamond Constr. Co., 184 Va. 711, 717, 36 S.E.2d 573, 576 (1946)).

In the present case, the claimant seeks review of an Opinion issued on March 24, 2016. In accordance with the 30-day jurisdictional limit, the claimant's Request for Review must have been filed on or before Monday, April 25, 2016.[3] The Commission's file shows the Commission did not receive the claimant's letter requesting review of the March 24, 2016 decision until April 18,

[3] The actual final date of the appeal period was Saturday, April 23, 2016; however, "[w]hen the last day for performing an act during the course of a judicial proceeding falls on a Saturday, Sunday, legal holiday, . . . the act may be performed on the next day that is not a Saturday, Sunday, legal holiday, ..." Va. Code § 1-210(B).

2017.[4] Accordingly, the claimant's Request for Review was filed almost one year late. We do not find evidence of any fraud or mutual mistake to allow the Commission to have jurisdiction over the case. Since the Request for Review was not filed within the appeal period, the March 24, 2016 Opinion is now final, and we have no jurisdiction to consider the claimant's review request.

III. Conclusion

We DISMISS the claimant's Request for Review.

We remove this matter from the review docket.

APPEAL

You may appeal this decision to the Court of Appeals of Virginia by filing a Notice of Appeal with the Commission and a copy of the Notice of Appeal with the Court of Appeals of Virginia within 30 days of the date of this Opinion. You may obtain additional information concerning appeal requirements from the Clerk's Offices of the Commission and the Court of Appeals of Virginia.

[4] Pursuant to Va. Code § 65.2-101, "[f]iling by first-class mail, electronic transmission, or facsimile transmission shall be deemed completed only when the document or other material transmitted reaches the Commission or its designated agent."

VIRGINIA:
IN THE WORKERS' COMPENSATION COMMISSION

Amended Opinion[1] by BURKHOLDER
Deputy Commissioner

March 24, 2016

MARTY FOUST v. LAWRENCE BROTHERS, INC.
AMERICAN INTERSTATE INSURANCE COMPANY, Insurance Carrier
AMERICAN INTERSTATE INSURANCE COMPANY, Claim Administrator
Jurisdiction Claim No. VA00000463553
Claim Administrator File No. 201189641VA
Date of Injury April 18, 2011

J. Aaron Thomas, Esquire
For the Claimant.

Ramesh Murthy, Esquire
For the Defendants.

Hearing before Deputy Commissioner Burkholder at Lebanon, Virginia, on November 9, 2015.

PROCEDURAL HISTORY

The claimant sustained a compensable injury by accident arising out of and during the course of his employment on April 18, 2011. Upon stipulated facts, Deputy Commissioner Burchett issued an Opinion on January 5, 2012 reciting that the claimant sustained second and third degree burns to the chest, left elbow, abdomen/flank area and left upper extremity. The claimant was awarded medical benefits and an open period of temporary total disability benefits at the weekly rate of $403.33 based upon a pre-injury average weekly wage of $605.00.

This matter has an extensive procedural history subsequent to Deputy Commissioner Burchett's January 5, 2012 Opinion, which was set forth in detail in Deputy Commissioner Burkholder's October 28, 2014 Opinion in this matter. Having been previously recited, we omit repetition of the same.

[1] The Opinion was amended to address the requests for costs and attorney's fees that have been submitted by claimant's present and former counsel.

The most recent opinion of the Commission in this matter was issued April 3, 2015. That opinion held that the claimant had withdrawn his request for a panel of pain management physicians to replace Dr. Ajam.

PRESENT PROCEEDINGS

This matter is now before the Commission on the Employer's Application for Hearing filed June 10, 2015 and the claimant's request for hearing filed July 1, 2015 and amended on October 12, 2015.

The employer's June 10, 2015 application for hearing asserts that the claimant was released to return to his pre-injury employment per Dr. Richard Wilson's IME report of the same date, and that any continuing disability is not causally related to the claimant's April 18, 2011 compensable accident.

The claimant's July 1, 2015 request for hearing seeks to have Dr. Karvelas recognized as the claimant's authorized treating physician and seeks approval for EMG and nerve conduction studies ordered by Dr. Karvelas.[2] Claimant's amended claim filed October 12, 2015 asserts that the claimant suffered a stroke on or about May 28, 2012 and that the stroke should be recognized as a compensable consequence of the claimant's April 18, 2011 injuries.[3]

STIPULATIONS

None.

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[2] Claimant's counsel also filed a June 18, 2015 request for hearing in this matter which likewise requested approval for various treatment and/or referrals by Dr. Karvelas. For reasons which are not apparent from the record, claimant's June 18, 2015 request for hearing was never referred to the hearing docket. However, the issue appears to be moot. If Dr. Karvelas is recognized as an authorized treating physician, then the defendants would be responsible for any reasonable, necessary and causally related medical treatment rendered by or at his direction. Conversely, if Dr. Karvelas is determined to be an unauthorized physician, then the defendants would not be responsible for such treatment.

[3] At the hearing, claimant's counsel withdrew the amended claim asserting that the claimant's thoracic spine dysfunction at T7 was a compensable consequence of his original injuries, and that claim is dismissed without prejudice.

DEFENSES

In response to the Employer's Application for Hearing, the claimant's counsel asserted that the claimant was incapable of performing all of his pre-injury job duties and that the job description provided to the IME physician was inaccurate.

In response to the claimant's request for hearing, as amended, counsel for the employer and carrier asserted the following defenses: 1) Dr. Karvelas is not an authorized treating physician; 2) the medical treatment at issue is not reasonable, necessary or causally related to the claimant's compensable injury; and 3) the claimant's 2012 stroke is not a compensable consequence of the claimant's April 18, 2011 work related injury.

PRE-HEARING AND POST-HEARING EVIDENCE

The record was held open post-hearing for both counsel to submit revised medical designations and written argument with respect to the medical issues in dispute. Both counsel did so, and the record closed.

SUMMARY OF THE EVIDENCE

The claimant was the only witness to testify at the hearing. He described his work as a welder in an industrial factory which made heavy equipment for the mining industry. The claimant made battery boxes by welding pieces of steel together. The claimant brought steel to his work station using an overhead crane. The claimant's welding unit was mounted to the wall. The claimant testified that the welding unit used spools of wire and gas cylinders, which the claimant periodically had to change out. According to the claimant, the spools of wire weighed 50 or 60 pounds. The gas cylinders weighed 150 to 200 pounds, and they were moved on a hand

truck. The claimant said that he would have to "bear hug" the cylinders to maneuver them on and off the dolly when the cylinders for the welding unit needed to be exchanged.

The claimant described his work environment as extremely hot. He said that welding is the process of melting two pieces of steel together at a temperature of "thousands" of degrees. The claimant worked in a sheet metal building with no air conditioning and no fan. His work place was very hot even in the winter, and the claimant had to wear protective clothing as well. Since the claimant's burn injury, he can no longer stand for heat to hit his body. The claimant cannot tolerate being in the summer sun for very long. Cold temperatures in the winter are also a problem for him. Heat irritates his burns and causes him to have pain. The claimant does not believe that he could go back to his job as a welder because of the heat and because he can no longer use his left arm. Welding is a dangerous job, and the claimant's constant pain interferes with his concentration and the ability to do the job safely.

The claimant had a stroke on May 22, 2012, which he attributes to his burn injury. The burns damaged the claimant's lymph vessels, causing the arteries in his neck to get "clogged up". The claimant's system cannot clean away the plaque, and this caused the stroke. The claimant's stroke has affected his left arm and left leg, causing those limbs to be weak. Dr. Johnson explained that the claimant's lymph vessels were burned, and that they are not working as they should.

The claimant testified that Dr. Karvelas was his authorized treating physician before March 2015. He subsequently acknowledged that Dr. Badlani came first. He said that his relationship with Dr. Badlani ended because she retired. Dr. Karvelas told the claimant that Dr. Badlani had retired. Dr. Badlani's office referred the claimant to Dr. Karvelas. The claimant

testified that he asked the insurance carrier for a panel of physicians when Dr. Badlani retired, and that he was not given one. After that, he accepted Dr. Karvelas. Dr. Karvelas has referred the claimant to a plastic surgeon, Dr. Molnar; a neurologist, Dr. Husseini; an orthopedic surgeon, Dr. Wiesler; and to a neurosurgeon.

On cross-examination, the claimant said that he asked for a panel of physicians the last time that he had a hearing with the Commission. The claimant cannot remember the last time that he saw Dr. Badlani. He thinks it was in 2014, maybe. Dr. Karvelas is a physical medicine and rehabilitation specialist, like Dr. Wilson. The claimant testified that he thought Dr. Badlani was a neurologist, but she was not. She was also a physical medicine and rehabilitation doctor, like Dr. Wilson. The claimant stated that he is "positive" of this.

Dr. Molnar, the plastic surgeon, referred the claimant to Dr. Badlani and to Dr. Ajam "after he [Dr. Molnar] cut me loose and everything." Dr. Badlani "didn't do nothing" for the claimant. Dr. Karvelas has sent the claimant "everywhere." The claimant went to the University of North Carolina Hospital on his own. Dr. Karvelas read the records from UNC and got the ball rolling for the claimant.

The claimant testified that his stroke and the burns have made his left arm weak and that "you need both arms when you're welding." The weight of the wire spools would be listed on the boxes. The claimant did not study the weights on the boxes. He would just take a spool out of the box and load it onto the welding machine. The claimant had only worked for one week at the time of his injury. The claimant states he does fine at room temperature; however, both extreme heat and cold bother him.

Drs. Johnson, Wilson and Karvelas have never asked the claimant about his specific job duties. They only asked him what he did, and he answered, "I'm a welder." The claimant has seen Dr. Karvelas twice. He has seen Dr. Johnson two or three times. Dr. Johnson specializes in "everything." The claimant was sent to Dr. Baylor by the attorneys who previously represented him. The claimant has not taken a job description to any of his doctors. His lawyers told the doctors that the claimant was a welder.

The claimant never weighed the chains used to move the steel panels. He never weighed the gas cylinders.

On re-direct, the claimant testified that the hand truck used to move the gas cylinders had a lip about five inches high to keep the cylinders from rolling off. The claimant would have to lift the cylinders up and over this lip in order to get them on or off the hand truck. The claimant had to bend over and bear hug the cylinder in order to do this. After picking up the cylinder, the claimant would have to turn around while holding the cylinder and place it in position at the welding machine. When the claimant saw Dr. Wilson for the IME in June of 2015, Dr. Wilson did not ask the claimant about his job duties.

The medical evidence in this claim is voluminous. A great deal of that evidence was previously summarized in detail in the Deputy Commissioner's October 28, 2014 Opinion in this matter. Both parties have submitted written argument referencing the medical records relied upon in support of their respective positions. Therefore, we will dispense with any further summary of the medical evidence and proceed to address the issues for adjudication.

FINDINGS OF FACT AND RULINGS OF LAW

Return to Pre-Injury Employment

Based upon Dr. Wilson's IME report, the defendants assert that the claimant is now capable of performing his pre-injury work. They acknowledge that the claimant does have some restrictions as a result of his injury, but they contend that the claimant's pre-injury job description[4] comes within the limitations imposed as a result of his April 18, 2011 burn injury. Other limitations on the claimant's ability to work, they argue, are not causally related to the claimant's compensable injury. The claimant opposes Dr. Wilson's opinion with records and opinions from Dr. Reynaga, Dr. Johnson, Dr. Husseini and Nurse Practitioner Pitchford. Claimant argues that these providers have either taken the claimant completely out of work or imposed limitations more restrictive than those referenced by Dr. Wilson.

The parties' dispute over the claimant's work capacity is permeated by the issue of causation. The defendants take the position that the claimant has two limitations from his burn injury. He is restricted to fifty pounds total lifting and no use of the left arm above chest level or overhead.[5] They maintain that any other limitations, such as weakness and impairment caused by the claimant's stroke, are not causally related to the compensable injury. The claimant asserts the opposite position, arguing that the claimant's 2012 stroke is a compensable consequence of the injury at issue. We resolve this issue utilizing familiar principles of law.

In an application for a review of an award on the grounds of a change in condition, the burden is on the party alleging such change to prove the parties' allegations by a preponderance of the evidence. Pilot Freight Carriers, Inc. v. Reeves, 1 Va. App. 435, 438, 339 S.E.2d 570, 572

[4] See Item 5 on Defendant's Designation of Medical Evidence.
[5] See Item 4 on Defendant's Designation of Medical Evidence.

(1986). In the present case, the claimant has an open award. Therefore, the defendants have the burden of proving that the claimant is fully able to perform all the tasks that were required or expected of him in his work at the time of his accident. Celanese Fibers Co. v. Johnson, 229 Va. 117, 326 S.E.2d 687 (1985).

Dr. Wilson's opinion is based upon the job description supplied by the employer. That description reads as follows:

> **Welder**: Performs general MIG welding activity, grinding and smoothing of weld seams; lines up parts, using tape measure, to blueprint specification, prior to welding; works with other lead welders and quality checkup finished products; cleanup of work area; works with welding gases and wires; uses overhead grind to move items over 40 pounds into and out of welding base; may be required to carry metal items up to 40 pounds, a short distance.

The written job description was the only evidence of the claimant's work activities submitted by the employer. The claimant testified about various tasks that his welding job required. Specifically, he testified that he had to load spools of wire into his welding machine, and that he had to lift gas cylinders both on and off a hand truck and maneuver them into place when the gas supply for his welding machine had to be replenished. The claimant testified that the gas cylinders weighed 150 to 200 pounds and that the spools of wire weighed 50 or 60 pounds, depending on the size of the wire being used.

The claimant's description of his job tasks appeared to be plausible and in line with the conditions that one would expect to encounter inside an industrial manufacturing facility. Therefore, we certainly cannot say that the claimant's testimony on this subject should be accorded no evidentiary weight whatsoever. We hold that the evidence fails to sustain the employer's burden of proof. On the evidence presented, we find that it is more probable than not

that the claimant's pre-injury job would require him to lift more than 50 pounds and that it would also require him to use his left arm above chest height when servicing the welding machine.

On the present record, we also find that the Employer's Application for Hearing should be denied for an additional reason. The medical evidence as a whole does not preponderate in favor of Dr. Wilson's position that the claimant's only restrictions causally related to his compensable injury are no lifting more than 50 pounds and no use of the left arm above chest level. As argued by claimant's counsel, several providers have opined that the claimant is either completely incapacitated or limited to restrictions more severe than those set forth in Dr. Wilson's IME report.

The medical records in this matter consistently report the assessment that the claimant suffers from "neuropathic pain" that is related to his burn injury. This assessment is documented in records submitted both before and after the employer's current application for hearing was filed. On balance, we find that the greater weight of the medical evidence supports the conclusion that, although there may be multiple causes for the claimant's disability, the compensable injury remains at least one of the causes for that disability. Therefore, the claimant is entitled to indemnity benefits under the two causes rule.

When the evidence shows that an employee's disability has two causes, one related to the employment and one unrelated, the two causes rule governs. Smith v. Fieldcrest Mills, Inc. 224 Va. 24, 28, 294 S.E.2d, 805, 808 (1982); Bergmann v. L & W Drywall, 222 Va. 30, 32, 278 S.E.2d 801, 803 (1991). The two causes rule provides that a condition which has two causes, one related to a work injury, and one not, is compensable and the responsibility of the employer. See Shelton v. Ennis Bus. Forms, Inc., 1 Va. App. 53, 55, 334 S.E.2d 294, 299 (1985). The

extent or degree to which the work-related cause contributed is not important. It matters only that the work-related cause contributed in some part to claimant's disability. Bergland Chevrolet, Inc. v. Landrum, 43 Va. App. 742, 753, 601 S.E.2d 693, 698 (2004); Henrico Cnty. Sch. Bd. v. Etter, 36 Va. App. 437, 446, 552 S.E.2d 372, 376 (2001). Accordingly, we hold that the Employer's Application for Hearing should be denied for these reasons as well.

Recognition of Dr. Karvelas as Authorized Treating Physician

The claimant proposes several grounds for the Commission to recognize Dr. Karvelas as an authorized treating physician. Claimant's counsel asserted that Dr. Karvelas became the claimant's treating physician when Dr. Badlani retired. The claimant testified at the hearing that Dr. Badlani referred him to Dr. Karvelas. He also testified that he asked the insurance carrier for a panel of physicians when Dr. Badlani retired and that the carrier refused to provide one. Therefore, claimant's counsel argues that the defendants should be bound by the claimant's choice of Dr. Karvelas.

For the reasons which follow, we find that the claimant's positions are not well taken. We determine that Dr. Karvelas is not an authorized treating physician within the chain of referral, and we hold that treatment rendered by or at the direction of Dr. Karvelas is unauthorized and shall not be the responsibility of the employer and carrier.

The claimant's memorandum asserted, "When the claimant's authorized treating physician, Dr. Bedlani [sic], retired, Wake Forest Baptist Medical Center referred claimant to Dr. Karvelas."[6] The claimant first saw Dr. Karvelas on June 16, 2015. The office note reflects that the referring provider was Dr. Ajam. We find this reference puzzling, to say the least. For the reasons discussed at length in the Deputy Commissioner's October 28, 2014 Opinion in this

[6] Cl's W.S. 5, n.1.

matter, Dr. Ajam discharged the claimant as a patient in October 2013. We have no explanation for Dr. Ajam's purported referral of claimant to Dr. Karvelas more than a year and a half after Dr. Ajam had dismissed the claimant from his practice.

Likewise, we find nothing in the record to substantiate the claimant's assertions that Dr. Badlani had retired or that Dr. Karvelas is a member of the same practice as Dr. Badlani, who assumed the care of Dr. Badlani's patients upon her retirement. We find no record that the claimant saw Dr. Badlani more recently than 2013, and the claimant was quite adamant in his testimony at the August 2014 hearing that he did not wish to see Dr. Badlani again. Therefore, we find that the greater weight of the evidence does not support the assertion that Dr. Badlani somehow referred the claimant to Dr. Karvelas or transferred his care to Dr. Karvelas.

Likewise, the claimant's assertion that he had asked the carrier for a panel of physicians to replace Dr. Badlani and that the carrier refused to provide such a panel is not borne out by the record. The August 26, 2014 hearing in this matter was held on the claimant's request for a panel of physicians to replace Dr. Ajam. In his testimony at the November 9, 2015 hearing, the claimant clearly stated that he had asked for a panel in the previous hearing. The record does not reflect that the claimant has ever requested a hearing to obtain a panel of physicians to replace Dr. Badlani.

The Commission's April 3, 2015 Opinion determined that the claimant had withdrawn his request for a panel to replace Dr. Ajam. That ruling is has long since become final. We find that the claimant has submitted no other request for a panel of physicians in this matter other than the request for a replacement of Dr. Ajam that was at issue in the October 28, 2014 Opinion

and the April 3, 2015 Review Opinion. Hence, we reject the assertion that the defendants should be required to accept Dr. Karvelas as a treating physician because they have failed to provide the claimant with a panel to replace Dr. Badlani.

The claimant also put forward an alternative argument as follows: Even if the Commission finds Dr. Karvelas to be unauthorized, much of the requested medical testing and treatment has been ordered by Dr. Molnar, who was the claimant's authorized treating plastic surgeon. The claimant's argument fails for two reasons. First, Dr. Molnar released the claimant from any further treatment on April 8, 2013. Hence, when the claimant saw Dr. Molnar in 2015, Dr. Molnar was no longer an authorized treating physician. Second, the current referral to Dr. Molnar came from an unauthorized physician.

Dr. Karvelas had recommended that the claimant follow up with "plastics where he is cleared to go per his insurance." Dr. Molnar's office note for August 19, 2015, however, recites the chain of referral as follows:

> HISTORY: Marty D. Foust is a 60 y.o. male who presents with past medication history significant for burn to left flank and shoulder region. Well known to me for previous treatment in 2013. Has been seen at Chapel Hill[7] after referral from a neurologist in WVA.

Thus, we reject the assertion that Dr. Molnar is an authorized treating physician. He had released claimant from treatment more than two years prior to August 19, 2015. If either Dr. Karvelas or the physicians at the University of North Carolina made the referral to Dr. Molnar, the source of the referral is an unauthorized physician. Although Dr. Molnar had been an authorized treating physician for the claimant at an earlier point in time, we hold that

[7] The medical record and testimony established that the claimant sought evaluation at the University of North Carolina, Chapel Hill on his own initiative.

simply referring the claimant back to Dr. Molnar two years after discharge is insufficient to make Dr. Molnar into an authorized treating physician again.

Claimant's Stroke as a Compensable Consequence of the April 18, 2011 Injury

The claimant asserts that his May 2012 stroke should be recognized as a compensable consequence of his original injury. In support of this position, the claimant relies upon the November 4, 2015 opinion of Matthew S. Johnson, D.O.[8] Dr. Johnson, a primary care physician, expressed the opinion that the burn injury damaged the lymphatic channels on the left side of the claimant's chest. As a result, the functioning of the claimant's lymphatic system has been compromised.

> Because Mr. Foust's lymph channels are compromised, and in some cases destroyed, his ability to clear plaques from arteries, remove debris, heal tissue and fight off infection are all compromised. His burns cover almost the exact area where the majority of lymph drainage into the chest collects in a healthy human.

Dr. Johnson goes on to explain that the claimant's impaired lymphatic function has allowed plaque to accumulate in claimant's left carotid artery with resulting stenosis. In turn, Dr. Johnson asserts that the stenosis of the claimant's left carotid artery is what caused the claimant to have an embolic stroke in May of 2012. The stroke affected the right side of claimant's brain, which controls the left side of the claimant's body, with resulting weakness of the left arm and left leg.

> The actual lesion showed itself on the right side, however, I am certain that the genesis of the actual debris originated on the left side of his body and travelled to the right side of his brain via common circulation pathways, most likely from his left common carotid, left carotid bulb, or deeper in his chest.

[8] See Item 28 on Claimant's Medical Evidence Designation

In disputing the claimant's position, the defendants rely on opposing positions regarding the origin of the claimant's stroke which have been rendered by Dr. Ajam, Dr. Baylor, and Dr. Wilson. The defendants also argue that even if Dr. Johnson's opinion were to be accepted, it sets forth a consequence of a compensable consequence which is not compensable under the Act. We agree.

According to the claimant's position, the burn injury caused damage to the lymphatic vessels. This would be a direct injury sustained in the compensable accident. As a result of the damage, Dr. Johnson asserts the claimant's lymphatic function has been compromised. This would be a compensable consequence of the original injury. In turn, Dr. Johnson states that the claimant has developed stenosis of the left carotid artery because the claimant's damaged lymphatic system is unable to clear away plaque. Plaque in the carotid artery is what caused the claimant to have a stroke.

The doctrine of compensable consequences does not apply to a consequence of a compensable consequence. Amoco Foam Products Co. v. Johnson, 257 Va. 29, 33, 510 S.E.2d 443, 445 (1999). There must be a direct causal connection between the compensable injury and the condition to be covered. Where A is the original injury, if A causes B, then B is covered as a compensable consequence. However, if A causes B, and B, in turn, causes C, then C is a consequence of a compensable consequence and is not covered under the present provisions of the Act. See Farmington Country Club v. Marshall, 47 Va. App. 15, 622 S.E.2d 233 (2005).

Thus, even if we were to accord preponderating evidentiary weight to Dr. Johnson's medical opinion, we could not find that the claimant's 2012 stroke is a compensable consequence of his original injury. Rather, under Amoco Foam Products and

Farmington Country Club, the claimant's stroke would be a noncompensable consequence of a compensable consequence rather than a compensable consequence of the original injury.

Additionally, and in the alternative, we do not find that Dr. Johnson's opinion is entitled to preponderating evidentiary weight. No evidence was presented to establish Dr. Johnson's qualification as a specialist in either cardiovascular or neurological matters. His assertion that the claimant sustained an embolic stroke on the right side of his brain as a result of stenosis in the left carotid artery appears to contain an inherent element of speculation. Furthermore, at least three physicians have rendered contrary opinions on the origin of claimant's stroke, and one of those physicians, Dr. Ajam, was a treating physician. Therefore, we find that Dr. Johnson's opinion is insufficient to sustain the claimant's burden of proof on this issue.

For the foregoing reasons, the employer's June 10, 2015 application for hearing will be denied. Likewise, the claimant's July 1, 2015 request for hearing and October 12, 2015 amended claim will also be denied.[9]

REQUESTS FOR COSTS AND ATTORNEY'S FEES

At various times during the pendency of the present litigation, attorneys who have represented the claimant have asserted claims for attorney's fees and/or expenses. The Commission issued a letter order to present and former counsel on March 4, 2016 allowing seven days for the attorneys to advise the Commission if they desired to have the Commission make a ruling upon their claims. Attorneys Aaron Thomas and Craig Davis responded within the time allowed by the Commission. Attorney Thomas requested an award of costs and attorney fees. Attorney Davis requested an award of costs to himself and his co-counsel, Charles Stacy. He

[9] Our holdings in this matter are dispositive of the issues raised by the claimant's June 18, 2015 request for hearing, and that request for hearing is hereby dismissed as well.

also asked the Commission to defer any action on his and Mr. Stacy's claim for attorney's fees until such time as there may be a settlement in the claimant's claim.[10]

By letter order issued March 14, 2016, the Commission granted the request to defer action on the Davis and Stacy claim for attorney's fees. The Commission also allowed an additional seven day period for counsel to make any further submissions in support of or opposition to Mr. Thomas' claim for costs and attorney's fees or the claim for costs by Mr. Davis and Mr. Stacy. Thereafter, Mr. Stacy submitted correspondence to the Commission on March 15 and March 21, 2016 in support of the Davis and Stacy claim for an award of costs.

Additionally, Attorney Karel Ryan filed a letter asserting a claim for attorney's fees with the Commission on March 14, 2016. The claimant, acting individually rather than through his counsel, filed a letter with the Commission on March 17, 2016. The claimant objected to the requests by Mr. Stacy and Mr. Davis and Ms. Ryan.

Having considered all of the foregoing, the Commission makes the following rulings. Attorney J. Aaron Thomas is awarded fees of $2,000 and costs of $1,619.05 to be deducted from accrued compensation. Attorneys Craig Davis and Charles Stacy are awarded costs of $7,081.66 to be deducted from accrued compensation.

Attorney Ryan represented the claimant between March 25, 2014 and July 21, 2014. The claimant was already under an open award of TTD benefits when Ms. Ryan noted her appearance. The only matter pending before the Commission during her representation was the request for a panel of physicians to replace Dr. Ajam, which had been filed by Attorney Davis. Claimant discharged Attorney Ryan, and she withdrew from the representation before the

[10] In his March 11, 2016 letter Attorney Davis wrote, "We would also ask that any award of attorney's fees be postponed until such time as there is a settlement in the claimant's claim given the nature of the settlement that was pending and later abandoned by the claimant at the time we were granted leave to withdraw as counsel."

hearing took place. Her present request for fees was also not filed within the time specified by the Commission's March 4, 2016 Order. For all of these reasons, we find that Attorney Ryan's request for attorney fees should be denied.

Accordingly, an award shall enter.

AWARD

An award is hereby entered for Marty D. Foust against Lawrence Brothers, Inc. and American Interstate Insurance Company, insurer, reinstating the Commission's January 5, 2012 award beginning June 12, 2015. All accrued benefits are to be paid in one lump sum, directly to claimant.

Medical benefits provided in Code § 65.2-603 are to continue as previously awarded.

From accrued compensation, an attorney's fee of $2,000 plus $1,619.05 in costs shall be deducted and paid directly to J. Aaron Thomas, Esquire, for legal services rendered to the claimant in this case.

Additionally, the total sum of $7,081.66 shall be deducted and paid directly to Craig B. Davis, Esquire, and Charles A. Stacy, Esquire, for costs incurred in their prior representation of claimant. Pursuant to their request, action on their claim for attorney fees is being deferred at this time.

This matter is removed from the hearing docket.

REVIEW

Any party may appeal this decision to the Commission by filing a Request for Review with the Commission within thirty (30) days of the date of this Opinion.